NAF HBP Benefits Information

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Prescription Drug Coverage

What is the difference between generic drugs and brand name prescriptions? What is it costing you? Recent marketing campaigns from the pharmaceutical companies make us think that name brands are better, right? Not necessarily. Prescription drugs can be expensive, but as an informed consumer you can make better decisions on how to spend your dollars.

While generic drugs use the same active ingredients and affect the body the same as their brand-name equivalents, brand-name prescriptions cost you more money.

The brand name of a drug is the name under which it was originally marketed, and is protected by patent for up to 20 years. When this patent expires, other manufacturers can produce the generic equivalent of the brand and sell it under its generic name. In general, the cost to the consumer immediately drops by 20 to 30 percent. Within two years, the price is usually up to 60 percent less.

For example, with the NAF HBP's 3 Tier prescription drug benefit you have a choice on how to spend your money towards prescriptions. Take Minocin (antibiotic) for example.Minocin, costs approximately $70.38, which you'd pay the $30 co-pay under the NAF HBP plan since the drug is not on the Aetna formulary. For the generic version Minocycline (same antibiotic) it costs approximately $49.60. In this case, the $10 co-pay would apply.

Prescription drugs not on the Aetna formulary have a $30 co-pay under the 3 Tier prescription drug benefit. The Aetna formulary is simply their list of preferred prescription drugs approved by the Food and Drug Administration. Brand name drugs are a $20 co-pay and all generic drugs are a $10 co-pay. You may find the Three-Tier/Open Formulary at www.aetna.com/formulary/index.html. You may also want to bring a copy of the formulary with you to your physician to find the best cost for the prescription you need.

Elimination of Diabetic Eye Exam Referrals Effective July 1, 2002

Effective July 1, 2002, Aetna is eliminating the referral requirement for diabetic members' annual dilated retinal exam (DRE) in the Point of Service (POS) plan. Diabetic members can now go directly to their eye care physician for their DRE. Medical literature underscores the importance of the DRE and finds that these exams can lead to earlier identification of problems and can prevent unnecessary blindness in diabetics.

By removing the referral requirement, Aetna hopes to achieve an increased screening rate for members and, over time, identify and prevent problems at an early stage. The screening exams are less costly than the disease/condition they screen. For example, blindness in diabetic patients cost the Federal Government $14,296 annually per patient under the age of 65, while the cost per patient for screening is $31.32 per year.

Types of providers affected by this change include Ophthalmologists, Corneal Specialists, Glaucoma specialists, Opticians, and Optometrists. The DRE can be performed as an outpatient or office based procedure.

The elimination of the referral will generate a need for the eye care physician performing the DRE to "close the loop" with the member's PCP by communicating the member's exam results to the member's PCP.

Coordination of Benefits (COB)

Coordination of Benefits (COB) applies when you are covered by more than one health or dental plan. The COB provision may reduce the benefits normally payable by taking into account payments made by any other group medical or dental plans in which you participate.

When there are two plans covering the same person, one plan will be considered the primary plan and the other plan will be considered secondary in establishing the order of benefit payment. The primary plan will pay benefits without consideration of any other medical or dental plan. The secondary plan determines any additional benefits payable by applying their COB provision.

First, you must submit your claim to your primary plan (Aetna for example). After they have paid their normal plan benefit, you must then submit the claim, along with the primary carrier's Explanation of Benefits, to your secondary plan. The secondary plan determines any additional benefits payable by applying their COB provision.

If your spouse, for example, has another primary insurance plan, the claim must be submitted to the primary plan first. After they have paid their normal plan benefit, you must then submit the claim, along with the primary carrier's Explanation of Benefits, to your secondary NAF HBP. The NAF HBP benefits are reduced by the benefits issued under the primary plan. The total benefits issued under the NAF HBP, as the secondary plan, will not exceed what the NAF HBP would have paid had it been the primary plan. You may call Aetna member services at 1-800-367-6276 for assistance with any questions regarding your NAF HBP.